STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 01 B. WING	08/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/09/11 Facility Number: 001145 Provider Number: 155616 AIM Number: 200120200 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Landmark Nursing and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility was determined to be of Type V (111) construction with a partial basement and fully sprinklered excluding the elevator equipment room and kitchen food cart room . The facility has a fire alarm system with smoke	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 122 and had a census of 61 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/17/11 The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 1. Based on observations and interview, the facility failed to ensure the smoke barriers in 1 of 119 room walls and 1 of 1 ceiling in the healthcare portion of the facility were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or	K0025	K025 1. The gaps noted on Wing 4 air handler room, Wing 4 dining room and Wing 3 air handler room were filled to seal penetrations. The gaps identified at the attic smoke barrier wall above Hall 4 North door were repaired and a fire barrier sealant was utilized. 2. All smoke barriers were inspected and no further	08/30/2011

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	wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 25 residents who reside on Wing 4 and 36 residents who reside on Wing 3. Findings include: Based on observation with the maintenance supervisor on 08/09/11 during a tour of the facility from 8:20 a.m. to 12:30 p.m., the Wing 4 air handler room had six, three inch gaps in the south wall drywall from electrical and water piping penetrations with no fire stopping material used to seal the penetrations and the Wing 4 main dining room had four, two inch gaps around the four ceiling sprinklers in the west dining room opening with no fire stopping material used to seal the penetrations. Furthermore, the Wing 3 air handler room had three, two inch gaps in the drywall ceiling around three, twenty four inch metal duct penetrations with no fire stopping material used to seal the penetrations. This was verified by the		infractions in barriers were noted. 3. Maintenance Director will audit smoke barriers with walk through rounds 5 times/week. 4. Maintenance Director will report findings to QA Committee, monthly for 3 months, quarterly thereafter. 5. Compliance Date: August 30, 2011	

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	maintenance supervisor at the time of observation and confirmed by the administrator at the 08/09/11 12:30 p.m. exit conference. 3.1-19(b) 2. Based on observations and interview, the facility failed to ensure 1 of 6 attic smoke barriers in the healthcare portion of the facility was constructed to provide at least a one half hour fire resistance rating. This deficient practice affects 25 residents who reside on Wing 4. Findings include: Based on observation with the maintenance supervisor on 08/09/11 at 11:45 a.m., the attic smoke barrier wall above the Hall 4 north set of smoke barrier doors had a four inch by four inch area of drywall missing on the east side of the attic smoke barrier wall. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the 08/09/11 12:30 p.m. exit conference. 3.1-19(b)			

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K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 13 hazardous areas, such as a room used for the storage of combustible equipment and combustible storage, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 25 residents who reside on the Wing 4, located adjacent to the main dining room. Findings include: Based on observation on 08/09/11 at 11:50 a.m. with the maintenance supervisor, the maintenance office storage room, which measured eighty square feet and stored three shelves of combustible paper, two lawn mowers filled with gasoline, and two, two and one half gallon full containers of gasoline, was not provided with a self closing device on the storage room door. This was verified by	K0029	K0029 1. An automatic door closer was installed on Maintenance Office Storage Room door. 2. All hazardous areas were audited and found to have the proper door closers in place. 3. Maintenance Director will audit hazardous area door closers with walk through rounds 5 times/week. 4. Maintenance Director will report findings to QA Committee, monthly for 3 months, quarterly thereafter. 5. Compliance Date: August 30, 2011	08/30/2011

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	the maintenance supervisor at the time of observation and confirmed by the administrator at the 08/09/11 12:30 p.m. exit conference. 3.1-19(b)			
K0033 SS=E	Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 Based on observation and interview, the facility failed to ensure the one hour fire rating of doors in the healthcare portion of the facility could be verified for 3 of 3 stairway doors in Wing 4. LSC 8.2.5.4 refers to 7.1.3.2.1 for enclosure of exits. LSC 7.1.3.2.1(a) says the separation shall have not less than a 1 hour fire resistance rating where the exit connects three stories or less. This deficient practice could affects 25 residents who reside on the Wing 4. Findings include: Based on observations on 08/09/11 during a tour of Wing 4 with the maintenance supervisor from 8:20 a.m. to 9:30 a.m., the fire rating for the stairway door to the Wing 4 elevator foyer stairway door to the second floor, the Wing 4 lobby stairway door to the second floor, and the kitchen	K0033	K0033 1. Paint was removed from Wing 4 Foyer Elevator Door, Lobby Stairway Door and the Kitchen Stairway Door revealing labeling validating each door is a 2.5 hour fire rated door. 2. All doors were inspected to ensure they are appropriate fire rated doors. 3. Maintenance Director will audit exit components with walk through rounds 5 times/week. 4. Maintenance Director will report findings to QA Committee, monthly for 3 months, quarterly thereafter. 5. Compliance Date: August 30, 2011	08/30/2011

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	stairway door to the basement could not be determined since the metal fire rating labels had been painted with brown paint. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the 12:30 p.m. exit conference on 08/09/11..			
K0047 SS=E	3.1-19(b) Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 1. Based on observation and interview, the facility failed to ensure 2 of 11 exits in the healthcare portion of the facility were provided with exit and directional signs to indicate the direction of travel to the primary exit or secondary exit. This deficient practice affects 25 resident who reside on Wing 4 and would use the Wing 4 west exit next to the nurses' station as a primary exit or the Wing 4 fire barrier doors between the Wing 4 and the Administration Hall as a secondary exit during an evacuation. Findings include: Based on observation on 08/09/11 at 8:45 a.m. with the maintenance supervisor, the Wing 4 posted evacuation maps were observed to show the Wing 4 nurses' station west exit as a primary exit and the Wing 4 foyer between the Wing 4 and the	K0047	K0047 1. An illuminated exit sign was added to the Wing 4 exit door, near the nurse's station. Directional indicators were added to the Wing 4 Corridor Exit and the light bulbs and batteries were replaced in the Exit Light of the Maintenance Office. 2. All Exit doors were inspected to ensure they are appropriately illuminated and have directional indicators. 3. Maintenance Director will audit all Exit doors to ensure they are appropriately illuminated and have directional indicators with walk through rounds 5 times/week. 4. Maintenance Director will report findings to QA Committee, monthly for 3 months, quarterly thereafter. 5. Compliance Date: August 30, 2011	08/30/2011

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	Administration Hall as a secondary exit. Based on observation in the center of the Wing 4 corridor near the nurses' station with the maintenance supervisor on 08/09/11 at 9:00 a.m., there was no illuminated exit sign mounted on the ceiling indicating the left hand direction of travel from the Wing 4 corridor to the Wing 4 west exit nor an illuminated exit sign above the Wing 4 to Administration Hall fire barrier doors to indicate a right hand or left hand turn to the east or west exits from the enclosed exit foyer. Furthermore, the only illuminated exit sign for the Wing 4 west nurses' station primary exit was mounted above the exit door and an illuminated exit sign on the right hand side of the Wing 4 to Administration Hall fire barrier wall. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the 12:30 p.m. exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 17 exit signs in the healthcare portion of the facility was provided with continuous illumination. This deficient practice does not affect any residents. Findings include:			

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	Based on observation with the maintenance supervisor on 08/09/11 at 11:55 a.m., the maintenance office exit sign above the exit door was not illuminated. Based on an interview with the maintenance supervisor on 08/09/11 at 12:00 p.m., the exit sign light bulbs are burned out. This was confirmed by the administrator at the 08/09/11 12:30 p.m. exit conference.			
K0056 SS=E	3.1-19(b) If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 2 of 119 rooms in the healthcare portion of the facility were provided with complete sprinkler coverage. This deficient practice could affect 25 resident who reside on Wing 4 near the Wing 4 elevator foyer. Findings include:	K0056	K0056 1. Sprinklers were installed in the Wing 4 Elevator Room and the Kitchen Food Cart Storage Room. 2. All rooms were inspected to ensure each room has a sprinkler installed. 3. Maintenance Director will validate any room additions will have a sprinkler.	08/30/2011

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	Based on observation on 08/09/11 during a tour of Wing 4 from 8:20 a.m. to 9:30 a.m. with the maintenance supervisor, the Wing 4 elevator equipment room and the kitchen food cart storage room were not provided with sprinkler coverage. This was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the 08/09/11 12:30 p.m. exit conference. 3.1-19(b)		4. Maintenance Director will report findings to QA Committee, monthly for 3 months, quarterly thereafter. 5. Compliance Date: August 30, 2011	
K0130 SS=E	OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure flammable liquids were stored in an approved storage cabinet or outside the facility in 1 of 1 rooms where flammable liquids were stored, maintained and/or utilized, to minimize the possibility of a fire emergency requiring the evacuation of the occupants to protect 61 of 61 residents. LSC 19.1.1.3 requires all health care facilities shall be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. NFPA 30, Flammable and Combustible Liquids Code, 4-5.1.4 requires liquids used for building maintenance, painting, or other similar infrequent maintenance purposes shall be permitted to be stored temporarily in	K0130	K130 1. Lawnmower and gas cans will be removed and no longer stored at the facility. 2. All areas were assessed for the presence of combustibles with no further combustibles found to be stored outside of an approved cabinet. 3. Maintenance Director will audit the storage of combustibles with walk through rounds 5 times/week. 4. Maintenance Director will report findings to QA Committee, monthly for 3 months, quarterly thereafter. 5 Compliance Date: August 30, 2011	08/30/2011

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	closed containers outside storage cabinets or inside liquid storage areas, if limited to an amount that does not exceed a 10 day supply at anticipated rates of use. 4-4.2.2 requires openings in interior walls to adjacent rooms or buildings and openings in exterior walls with fire resistance ratings shall be provided with normally closed, listed fire doors with fire protection ratings corresponding to the fire resistance rating of the wall as specified in Table 4-4.2.2. Such doors shall be permitted to be arranged to stay open during material handling operations if the doors are designed to close automatically in a fire emergency by provision of listed closure devices. Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. NFPA 30, 4-8.5 requires precautions shall be taken to prevent the ignition of flammable vapors. Sources of ignition include, but are not limited to: open flames, lighting, smoking, cutting or welding, hot sources, frictional heat, static electricity, electrical or mechanical sparks, spontaneous heating, including heat producing chemical reactions, and radiant heat. This deficient practice could affect 25 residents who reside on the Wing 4, located adjacent to the main dining room. Findings include:			

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	Based on observation on 08/09/11 at 11:50 a.m. with the maintenance supervisor, the maintenance office storage room had three shelves of combustible paper, two lawn mowers filled with gasoline, and two, two and one half gallon red plastic containers full of gasoline stored in the room. The walls in the maintenance office storage room were constructed of one hour construction, and the door to the maintenance office storage room was a nonrated wood door with no self closing device. Furthermore, the room was equipped with an electric light switch on the wall to operate a light fixture in the center of the room with a standard glass cover. Based on an interview with the maintenance supervisor on 08/09/11 at 12:00 p.m., the lawn mowers and gasoline containers are stored in the room throughout the year because the facility does not have an outside shed for lawn mower and gasoline storage. This was confirmed by the administrator at the 12:30 p.m. exit conference on 08/09/11. 3.1-19(b)			

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K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer locations was provided with a 45 minute fire rated door. This deficient practice affects 36 residents who reside on Wing 3. Findings include: Based on observation with the maintenance supervisor on 08/09/11 at 12:10 p.m., the Wing 3 liquid oxygen storage room, where eight full liquid oxygen containers were stored had a metal door with the fire rating label painted so the rating could not be determined. Based on an interview with the Wing 3 charge nurse and maintenance supervisor on 08/09/11 at 12:15 p.m., the charge nurse indicated the Wing 3 liquid oxygen storage room was also used as a	K0143	K143 1. The paint was removed from the Wing 3 Oxygen Storage Room Door revealing the label validating door is a 2.5 hour fire rated door. 2. All doors were inspected to ensure they are appropriate fire rated doors. 3. Maintenance Director will audit fire barrier doors with walk through rounds 5 times/week. 4. Maintenance Director will report findings to QA Committee, monthly for 3 months, quarterly thereafter. 5. Compliance Date: August 30, 2011	08/30/2011

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	transferring location to transfer liquid oxygen from large containers to smaller portable containers for resident use. At the 12:30 p.m. exit conference on 08/09/11, the administrator acknowledged the Wing 3 liquid oxygen storage room door fire rating label was painted hiding the door's rating. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions	K0144	K0144 1. The facility has the appropriate documentation to validate the facility is complying with the NFPA 110, 1999 testing requirements for emergency generators. 2. The Generator Testing Log Book is current, detailing the documentation for emergency generator testing. 3. Maintenance Director will continue to conduct monthly generator testing as per NFPA 110, 1999 testing requirements for emergency generators. 4. Maintenance Director will report findings to QA Committee, monthly for 3 months, quarterly thereafter. 5. Compliance Date: August 30, 2011	08/30/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors. Findings include: Based on a review of the Generator Testing Log Book on 08/09/11 at 11:45 a.m. with the maintenance supervisor, the Generator Testing Log Book showed a monthly load test for each of the past twelve months for thirty minutes and listed an amperage output during each load test conducted, with no indication of a thirty percent nameplate rated test. Based on an interview with the maintenance supervisor on 08/09/11 at 11:50 a.m., the monthly load tests are run for a thirty minute duration and there are no gauges to monitor operating temperatures while the generator is running on a thirty minute load test. The amperage output is listed because the emergency generator contractor who performs annual testing suggested listing amperage output to conform to the thirty percent rated load testing requirement. The lack of documentation in the Generator Testing Log Book of a monthly thirty percent rated load test was confirmed by the administrator at the 12:30 p.m. exit conference on 08/09/11. 3.1-19(b)			
K0044 SS=E	Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 02 B. WING	08/09/2011

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	Based on observation and interview, the facility failed to ensure 2 of 2 fire barrier door sets were provided with 1 1/2 hour fire rated doors. LSC 7.2.4.3.4 requires any opening in a fire harrier shall be protected as provided in 8.2.3.2.3. LSC 8.2.3.2.3.1 requires every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for openings shall be as follows: (1) 2-hour fire barrier-1 1/2 hour fire protection rating. This deficient practice affects 25 residents who reside on the Wing 4 and could use the Wing 4 south fire barrier doors as a horizontal exit during an evacuation. Findings include: Based on observation on 08/09/11 during a tour of Wing 4 from 8:20 a.m. to 9:30 a.m. with the maintenance supervisor, the Wing 4 set of fire barrier doors enclosing the two foyer exits between Wing 4 and the Administration Hall, and the Wing 4 to the lobby set of fire doors each lacked a fire rating label. Based on an interview	K0044	K0044 1. The documentation the 3 hour fire rating for Wing 4 set of fire barrier doors. has been validated and is in the facility. 2. All doors were inspected to ensure they are appropriate fire rated doors. 3. Maintenance Director will audit fire barrier doors with walk through rounds 5 times/week. 4. Maintenance Director will report findings to QA Committee, monthly for 3 months, quarterly thereafter. 5. Compliance Date: August 30, 2011	08/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	with the maintenance supervisor on 08/09/11 at 9:15 a.m., the Wing 4 foyer enclosure to the Administration Hall and Wing 4 to the lobby walls are both constructed of concrete and brick with a fire resistance rating of two hours. The lack of fire resistance ratings on the Wing 4 to the Administration Hall fire barrier doors and the Wing 4 to the lobby fire barrier doors was verified by the maintenance supervisor at the time of observation and confirmed by the administrator at the 12:30 p.m. exit conference 08/09/11. 3.1-19(b)			